



I, _____, give Twelve Bridges Vision Care Optometry permission to speak with the following people regarding my personal health information. This includes permission pertaining to diagnosis, treatment options and plans. It also includes permission to discuss payment for health services received from Twelve Bridges Vision Care Optometry. I understand that sharing health information with specialists and other health providers is necessary and not excluded by this form. This form gives Twelve Bridges Vision Care Optometry permission to share health information with nonprofessionals such as extended family members should I so desire.

This consent is valid until such time as I provide Twelve Bridges Vision Care Optometry written revocation of it.

Patient Name: _____

Patient DOB: _____

Twelve Bridges Vision Care Optometry may speak with:

1) **Name:** _____

Relationship: _____

2) **Name:** _____

Relationship: _____

3) **Name:** _____

Relationship: _____

Patient/Guardian Signature: _____

Date: _____